

Hospital Statement of Cost

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information PRELIMINARY

Name of Hospital: Mount Sinai Hospital		Medicare Provider Number: 14-0018	
Street: California Ave at 15th St.		Medicaid Provider Number: 3045	
City: Chicago	State: Illinois	Zip: 60608	
Period Covered by Statement:	From: 07/01/2018	To: 06/30/2019	

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> XXXX XXXX Other (Specify) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify) _____

Type of Hospital

<input type="checkbox"/> XXXX XXXX General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify) _____

Health Care Program

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

<input type="checkbox"/> XXXX XXXX Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II Rehab _____	<input type="checkbox"/> _____ _____
<input type="checkbox"/> Medicaid Sub I Psych _____	<input type="checkbox"/> Medicaid Sub III Other _____	<input type="checkbox"/> _____ _____

**NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishable
By Fine And / Or Imprisonment Under Federal Law**

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) Mount Sinai Hospital 3045 for the cost report beginning 07/01/2018 and ending 06/30/2019 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

Signed (Officer or Administrator of Provider(s)):

 Name (Typewritten)
 Title _____ Date _____
 Firm _____
 Telephone Number _____
 Email Address _____

 Name (Typewritten)
 Title _____
 Date _____
 Telephone Number _____
 Email Address _____

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Section 5 of the (305 ILCS 5/) Healthcare and Family Services Code (from Ch. 23, Par. 5). Failure to provide any information on or before the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Center.

PRELIMINARY

Medicare Provider Number: 14-0018	Medicaid Provider Number: 3045
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of Occupancy (Column 4 Divided By Column 2)	Number Of Admissions Excluding Newborn	Number Of Discharges Including Deaths Excluding Newborn	Average Length Of Stay By Program Excluding Newborn
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	182	66,430		32,544	48.99%		9,749	4.18
2.	Psych	28	10,220		7,118	69.65%		1,480	4.81
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	17	6,205		4,380	70.59%			
6.	Coronary Care Unit	12	4,380		3,802	86.80%			
7.	NICU								
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	25	9,125		1,902	20.84%			
22.	Total	264	96,360		49,746	51.63%		11,229	4.26
23.	Observation Bed Days				5,286				

Line No.	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				5,093			1,739	3.91
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				985				
6.	Coronary Care Unit				724				
7.	NICU								
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				1,479				
22.	Total				8,281	16.65%		1,739	3.91

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service		

PRELIMINARY

Medicare Provider Number: 14-0018	Medicaid Provider Number: 3045
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Cost to Charges (Col. 1 / 2)	Total Billed I/P Charges (Gross) for Health Care Program Patients (4)	Total Billed O/P Charges (Gross) for Health Care Program Patients (5)	I/P Expenses Applicable to Health Care Program (Col. 3 X 4) (6)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5) (7)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	20,222,240	95,279,858	0.212240	9,782,242		2,076,183	
2.	Recovery Room	2,626,271	37,120,273	0.070750	2,631,330		186,167	
3.	Delivery and Labor Room	6,565,979	33,284,174	0.197270	2,379,915		469,486	
4.	Anesthesiology	3,588,641	37,735,535	0.095100	3,753,862		356,992	
5.	Radiology - Diagnostic	12,367,453	75,384,807	0.164058	2,310,084		378,988	
6.	Radiology - Therapeutic	1,954,448	13,607,967	0.143625	294,871		42,351	
7.	Nuclear Medicine	1,002,679	5,192,067	0.193118	69,085		13,342	
8.	Laboratory	17,568,889	166,642,099	0.105429	9,419,241		993,061	
9.	Blood							
10.	Blood - Administration	2,629,066	6,814,439	0.385808	1,458,983		562,887	
11.	Intravenous Therapy							
12.	Respiratory Therapy	3,780,642	39,118,093	0.096647	4,821,036		465,939	
13.	Physical Therapy	819,328	2,451,471	0.334219	367,646		122,874	
14.	Occupational Therapy	823,280	2,954,737	0.278631	304,530		84,851	
15.	Speech Pathology	321,524	1,584,522	0.202915	326,838		66,320	
16.	EKG	2,493,373	26,415,928	0.094389	1,484,216		140,094	
17.	EEG	714,277	4,423,616	0.161469	96,815		15,633	
18.	Med. / Surg. Supplies	18,939,286	62,684,649	0.302136	10,107,904		3,053,962	
19.	Drugs Charged to Patients	16,565,043	100,799,476	0.164337	6,706,122		1,102,064	
20.	Renal Dialysis	4,023,719	21,624,709	0.186070	212,867		39,608	
21.	Ambulance							
22.	MRI	771,998	11,964,938	0.064522	724,929		46,774	
23.	O/P Chemotherapy	130,253	6,884,755	0.018919				
24.	Ear, Nose, Throat							
25.	Pulmonary Function	576,542	11,167,191	0.051628				
26.	Under The Rainbow							
27.	CT Scan	2,316,653	66,715,245	0.034724	4,175,164		144,978	
28.	Cardiac Catheterization	1,682,867	24,208,627	0.069515	1,300,425		90,399	
29.	SPASTICITY CLINIC	207,314	763,810	0.271421				
30.	HEM/ONC Clinic							
31.	MSH Specialty Clinic	781,973	9,154,126	0.085423				
32.	MSH Spec@Schwab	310,888	507,354	0.612763				
33.	MSH OP Behavioral Health	1,955,867	2,384,297	0.820312				
34.	Under The Rainbow	2,429,493	2,088,065	1.163514				
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic							
44.	Emergency	16,375,977	142,913,590	0.114587	644,805		73,886	
45.	Observation	6,652,907	14,218,685	0.467899	36,098		16,890	
46.	Total				63,409,008		10,543,729	

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to CMS 2552, W/S C charges to recompute the department cost to charge ratio.

PRELIMINARY

Medicare Provider Number: 14-0018	Medicaid Provider Number: 3045
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	46,791,631	7,547,974		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	37,830	7,118		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,236.89	1,060.41		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	5,093			
3.	Program general inpatient routine cost (Line 1c X Line 2)	6,299,481			
4.	Average per diem private room cost differential (BHF Supplement No. 1, Part II, Line 6)				
5.	Medically necessary private room days applicable to the program (BHF Page 2, Pt. II, Col. 3)				
6.	Medically necessary private room cost applicable to the program (Line 4 X Line 5)				
7.	Total program inpatient routine service cost (Line 3 + Line 6)	6,299,481			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	Average Per Diem (Col. A / Col. B)	Program Days (BHF Page 2, Part II, Col. 4)	Program Cost (Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit	6,285,129	4,380	1,434.96	985	1,413,436
9.	Coronary Care Unit	6,098,111	3,802	1,603.92	724	1,161,238
10.	NICU					
11.	Other					
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	1,171,644	1,902	616.01	1,479	911,079
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					10,543,729
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					20,328,963

Hospital Statement of Cost

Apportionment of Cost of Services Rendered by Interns and Residents Not in an Approved Teaching Program

PRELIMINARY

Medicare Provider Number: 14-0018	Medicaid Provider Number: 3045
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	NICU						
9.	Other						
10.	Other						
11.	Other						
12.	Other						
13.	Other						
14.	Other						
15.	Other						
16.	Other						
17.	Other						
18.	Other						
19.	Other						
20.	Other						
21.	Nursery						
22.	Subtotal Inpatient Care Svcs. (Lines 2 through 21)						

Line No.	Hospital Outpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Lines 88-93)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
						Inpatient (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	Total (Sum of Lines 22 and 26)								

PRELIMINARY

Medicare Provider Number: 14-0018	Medicaid Provider Number: 3045
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Line No.	Cost Centers	Professional Component	Total Dept. Charges	Ratio of Professional	Inpatient Program	Outpatient Program	Inpatient Program	Outpatient Program
		(CMS 2552-10, W/S A-8-2, Col. 4)	(CMS 2552-10, W/S C, Pt. 1, Col. 8)*	to Charges (Col. 1 / Col. 2)	Charges (BHF Page 3, Col. 4)	Charges (BHF Page 3, Col. 5)	Expenses for H B P (Col. 3 X Col. 4)	Expenses for H B P (Col. 3 X Col. 5)
Inpatient Ancillary Cost Centers		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	MRI							
23.	O/P Chemotherapy							
24.	Ear, Nose, Throat							
25.	Pulmonary Function							
26.	Under The Rainbow							
27.	CT Scan							
28.	Cardiac Catherization							
29.	SPASTICITY CLINIC							
30.	HEM/ONC Clinic							
31.	MSH Specialty Clinic							
32.	MSH Spec@Schwab							
33.	MSH OP Behavioral Health							
34.	Under The Rainbow							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Ancillary Cost Centers								
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	Ancillary Total							

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the professional component to total charge ratio.

PRELIMINARY

Medicare Provider Number: 14-0018	Medicaid Provider Number: 3045
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Line No.	Cost Centers	Professional Component	Total Days Including Private	Professional Component Cost Per Diem	Program Days Including Private	Outpatient Program Charges	Inpatient Program Expenses	Outpatient Program Expenses
		(CMS 2552-10, W/S A-8-2, Col. 4)	(CMS 2552-10, W/S S-3, Pt. 1, Col. 8)	(Col. 1 / Col. 2)	(BHF Pg. 2 Pt. II, Col. 4)	(BHF Page 3, Col. 5)	(Col. 3 X Col. 4)	(Col. 3 X Col. 5)
Routine Service Cost Centers		(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics							
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	NICU							
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)							
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)							

Computation of Lesser of Reasonable Cost or Customary Charges

PRELIMINARY

Medicare Provider Number: 14-0018		Medicaid Provider Number: 3045	
Program: Medicaid-Hospital		Period Covered by Statement: From: 07/01/2018 To: 06/30/2019	
Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	20,328,963	
3.	Interns and Residents Not in an Approved Teaching Program (BHF Page 5, Line 27, Cols. 6a and 6b)		
4.	Hospital Based Physician Services (BHF Page 6, Line 69, Cols. 6 & 7)		
5.	Services of Teaching Physicians (BHF Supplement No. 1, Part 1C, Lines 7 and 8)		
6.	Graduate Medical Education (BHF Supplement No. 2, Cols. 6 and 7, Line 69)	1,320,647	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	21,649,610	
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	100.00%	

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	63,409,008	
10.	Inpatient Routine Services (Provider's Records)		
A.	Adults and Pediatrics	15,247,101	
B.	Psych		
C.	Rehab		
D.	Other (Sub)		
E.	Intensive Care Unit	5,336,730	
F.	Coronary Care Unit	3,417,823	
G.	NICU		
H.	Other		
I.	Other		
J.	Other		
K.	Other		
L.	Other		
M.	Other		
N.	Other		
O.	Other		
P.	Other		
Q.	Other		
R.	Other		
S.	Other		
T.	Nursery	3,471,483	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	90,882,145	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		69,232,535
14.	Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2, Minus Line 12)		
15.	Excess Reasonable Cost Applicable to Inpatient and Outpatient (Line 8, Each Column X Line 14)		

PRELIMINARY

Medicare Provider Number: 14-0018	Medicaid Provider Number: 3045
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Line No.	Allowable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	21,649,610	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	21,649,610	
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (BHF Page 9, Part III, Line 4, Cols. 2B & 3B)		
5.	Protested Amounts (Nonallowable Cost Items) In Accordance With CMS Pub. 15-II, Ch. 1, Sec. 115.2		
6.	Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)	21,649,610	

Line No.	Total Amount Received / Receivable	Program Inpatient	Program Outpatient
		(1)	(2)
7.	Amount Received / Receivable From:		
	A. State Agency		
	B. Other (Patients and Third Party Payors)		
8.	Total Amount Received / Receivable (Sum of Lines 7A and 7B)		
9.	Balance Due Provider / (State Agency) * (Line 6 Minus Line 8)		

* Line 9 DOES NOT APPLY to the Medicaid program.

PRELIMINARY

Medicare Provider Number: 14-0018	Medicaid Provider Number: 3045
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under 42 CFR Section 405.460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	69,232,535
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period (4)	Sum of Columns 1 - 4 (5)
		to	to	to		
		(1)	(2)	(3)		
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2) (1)	Inpatient		Outpatient	
			Ratio (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (3B)
			(2A)	(2B)	(3A)	(3B)
1.	Cost Report Period ended					
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	Total (Sum of Lines 1 - 3)					

Teaching Physicians / Routine Services Questionnaire

PRELIMINARY

Medicare Provider Number: 14-0018	Medicaid Provider Number: 3045
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Part I - Apportionment of Cost for the Services of Teaching Physicians

Part A. Cost of Physicians Direct Medical and Surgical Services

1. Physicians on hospital staff average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 2, Line 3)	
3. Total Per Diem (Line 1 Plus Line 2)	

Part B. Program Data

	General Service	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
4. Program inpatient days (BHF Page 2, Part II, Column 4)				
5. Program outpatient occasions of service (BHF Page 2, Part III, Line 1)				

Part C. Program Cost

	General Service	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
6. Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
7. Program outpatient cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. Gross Routine Revenues				
(A) General inpatient routine service charges (Excluding swing bed charges) (CMS 2552-10, W/S D - 1, Part I, Line 28)				
(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552-10, W/S D - 1, Part I, Line 30)				
(C) Private room charges (A Minus B) or (CMS 2552-10, W/S D-1, Part 1, Line 29)				
2. Routine Days				
(A) Semi-private general care days (CMS 2552-10, W/S D - 1, Part I, Line 4)				
(B) Private room days (CMS 2552-10, W/S D - 1, Part I, Line 3)				
3. Private room charge per diem (1C Divided by 2B) or (CMS 2552-10, W/S D-1, Part 1, Line 32)				
4. Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552-10, W/S D-1, Part 1, Line 33)				
5. Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552-10, W/S D-1, Part 1, Line 34)				
6. Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552-10, W/S D-1, Part I, Line 27) Divided by (Line 1A Above))				
7. Private room cost differential adjustment (Line 2B X Line 6)				
8. General inpatient routine service cost (net of swing bed and private room cost differential) (CMS 2552-10, W/S D-1, Part I, Line 37)				
9. Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to BHF Page 4, Line 1c)				

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

PRELIMINARY

Medicare Provider Number: 14-0018	Medicaid Provider Number: 3045
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of G M E Cost to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Inpatient Ancillary Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	1,390,166	95,279,858	0.014590	9,782,242		142,723	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	114,109	37,735,535	0.003024	3,753,862		11,352	
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	142,329	26,415,928	0.005388	1,484,216		7,997	
17.	EEG	158,280	4,423,616	0.035781	96,815		3,464	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	MRI							
23.	O/P Chemotherapy							
24.	Ear, Nose, Throat							
25.	Pulmonary Function							
26.	Under The Rainbow							
27.	CT Scan							
28.	Cardiac Catherization							
29.	SPASTICITY CLINIC							
30.	HEM/ONC Clinic							
31.	MSH Specialty Clinic							
32.	MSH Spec@Schwab							
33.	MSH OP Behavioral Health							
34.	Under The Rainbow							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	614,716	142,913,590	0.004301	644,805		2,773	
45.	Observation							
46.	Ancillary Total						168,309	

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the G M E cost to total charge ratio.

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(b)

PRELIMINARY

Medicare Provider Number: 14-0018	Medicaid Provider Number: 3045
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Days Including Private (CMS 2552-10, W/S S-3, Pt. 1, Col. 8)	GME Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics	7,653,890	37,830	202.32	5,093		1,030,416	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	385,271	4,380	87.96	985		86,641	
52.	Coronary Care Unit	185,273	3,802	48.73	724		35,281	
53.	NICU							
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						1,152,338	
68.	Ancillary Total (from line 46)						168,309	
69.	Total (Lines 67-68)						1,320,647	

**Hospital Statement of Cost
Reconciliation of Patient Days and Revenue**

PRELIMINARY

Medicare Provider Number: 14-0018	Medicaid Provider Number: 3045
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	7,080	(278)	6,802
Newborn Days	1,479		1,479
Total Inpatient Revenue	90,882,145		90,882,145
Ancillary Revenue	64,596,805	(1,187,797)	63,409,008
Routine Revenue	26,285,340	1,187,797	27,473,137
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

- Reclassified Blood as Blood-Admin
- BHF Page 2 - Removed Labor & Delivery days- 1,787 - from filed Adults & Peds days in Part I, Line 1, Column 4.
- BHF Page 3-Implant Devices costs & charges are included with Medical Supplies from the Medicare report.
- BHF Page 3 - Placed \$1,187,797 filed Medicaid charges in "Other" with Adults & Peds on BHF Page 7. No "Other" cost center.
- Costs for Nursery were allocated between Mt. Sinai and Sinai Children's Hospitals per attached spreadsheet